

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 29 1959

59-025884

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 169

STATE FILE NUMBER 1

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Livingston</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		Length of stay in lb <u>few mins.</u>		c. CITY OR TOWN <u>Chillicothe</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chillicothe Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>RFD. #4</u> (If outside, give location) <u>1 1/2 Mi. W. of City Limits</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>PRICE GOULD STOCKTON</u>				4. DATE OF DEATH Month Day Year <u>July 18 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10-17-1889</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Santa Fe R.R.</u>		11. BIRTHPLACE (City and state or country) <u>Ashland, Kansas</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John B. Stockton</u>			13b. MOTHER'S MAIDEN NAME <u>Jessie Gould</u>		14. NAME OF HUSBAND OR WIFE <u>Opal Graham</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WWI</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Mrs. Opal Stockton RR#4</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Wound, Penetrating, Occipital Lobe of Brain</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							ONSET AND DEATH <u>2 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Sunshot wound from Rt. Posterior parietal region to left posterior parietal area</u>					
20c. TIME OF INJURY Hour <u>6</u> a.m. <u>7, 18, 59</u>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		20e. CITY, TOWN, OR LOCATION <u>R4, Chillicothe, Livingston, Mo</u>		20f. COUNTY STATE	
21. I attended the deceased from <u>7:30 am.</u> Death occurred at <u>7:30 am.</u>		Name <u>Name</u> to <u>Name</u> her alive on <u>July 18, 59</u> and last saw him					
22a. SIGNATURE <u>Joseph A. Conrad M.D. (Coroner)</u>				22b. ADDRESS <u>Chillicothe, Mo</u>		22c. DATE SIGNED <u>July 21, 59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7/20/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Edgewood Cemetery</u>		23d. LOCATION (City, town, or county) <u>Chillicothe, Missouri</u>		23e. (State)	
24. FUNERAL DIRECTOR <u>NORMAN FUNERAL HOME</u>			ADDRESS <u>Chillicothe, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>7/21/59</u>	26. REGISTRAR'S SIGNATURE <u>Francis B. Nell</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0961 6 2 70r

SEP 9

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John Polin

Licensed Embalmer No. 5035

P. O. Address Chillicothe,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.